

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT
(PA/CADTA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA) Completion Instructions, HCF 11040A.

☐ Initial Request ☐ First Reauthorization ☐ Second Reauthorization ☐ Subsequent Reauthorization

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Age — Recipient
3. Recipient Medicaid Identification Number	

SECTION II — PROVIDER INFORMATION

4. Name — Day Treatment Provider	5. Day Treatment Provider's Medicaid Provider Number
6. Name — Contact Person	7. Telephone Number — Contact Person

SECTION III — DOCUMENTATION

8. Indicate the requested start date and end date for this authorization period. If the requested start date is earlier than the date the prior authorization request form is first received by Wisconsin Medicaid, specifically request backdating and state clinical rationale for starting services before prior authorization is obtained.

9. Indicate the number of hours of treatment to be provided over the PA grant period. Indicate the pattern of treatment (e.g., three hours per day, three days per week for eight weeks).

SECTION III — DOCUMENTATION (Continued)

The following additional information must be provided. If copies of existing records are attached to provide the information requested, *limit attachments to two pages for the psychiatric evaluation and illness / treatment history*. Highlighting relevant information is helpful. *Do not attach M-Team summaries, additional social service reports, court reports, or similar documents unless directed to do so following initial review of the documentation.*

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10. Present a summary of the recipient's diagnostic assessment and differential diagnosis. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. *Diagnoses on all five axes of the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) are required.*

SECTION III — DOCUMENTATION (Continued)

11. Summarize the recipient's illness / treatment / medication history and other significant background information. Indicate why the provider thinks day treatment will produce positive change.

SECTION III — DOCUMENTATION (Continued)

12. Complete the checklist to determine whether an individual meets the criteria for severe emotional disturbance (SED). Criteria for meeting the functional symptoms and impairments are found in the instructions. *The disability must be evidenced by a, b, c, and d listed below.*

- a. A primary psychiatric diagnosis of mental illness or severe emotional disorder. Document diagnosis using the most recent version of the American Psychiatric Association DSM.

Primary Diagnosis Code and Description

- b. **The individual must meet all three of the following conditions:**

- ☐ Individual is under the age of 21.
- ☐ Individual's emotional and behavioral problems are severe in nature.
- ☐ The disability for which the individual is seeking treatment is expected to persist for a year or longer.

- c. **Symptoms and functional impairments**

The individual must have one of the following symptoms or two of the following functional impairments:

1. Symptoms

- ☐ Psychotic symptoms.
- ☐ Suicidality.
- ☐ Violence.

2. Functional impairments

- ☐ Functioning in self care.
- ☐ Functioning in the community.
- ☐ Functioning in social relationships.
- ☐ Functioning in the family.
- ☐ Functioning at school / work.

- d. **The individual is receiving services from two or more of the following service systems:**

- ☐ Mental health.
- ☐ Social services.
- ☐ Child protective services.
- ☐ Juvenile justice.
- ☐ Special education.

Eligibility criteria are waived under the following circumstances:

- ☐ The individual substantially meets the criteria for SED, except that the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning but would likely do so without child/adolescent day treatment services. Attach an explanation.
- ☐ The individual substantially meets the criteria for SED, except that the individual has not yet received services from more than one system and, in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

13. Describe the treatment program that will be provided. Attach a day treatment program schedule, if available. Summarize the proposed intervention in this section. The treatment plan should specify how program components relate to this client's treatment goals.

SECTION III — DOCUMENTATION (Continued)

14. Indicate the rationale for day treatment. Elaborate on this choice if prior outpatient (clinic) treatment is absent or limited. Why does the recipient need this level of intervention at this time?

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15. Indicate the expected date for termination of day treatment. Describe the anticipated service needs following completion of day treatment and the transition plan.

SECTION IV — ATTACHMENTS AND SIGNATURE

16. The following materials must be attached and *labeled*:

- a. A physician's prescription for day treatment services, signed by a physician, preferably a psychiatrist, dated not more than one year prior to the requested first date of service (DOS).
- b. Documentation that the recipient had a comprehensive HealthCheck screen dated not more than one year prior to the requested DOS. A copy of this documentation must be attached for reauthorizations. (A copy of the original documentation may be used.) *The initial request for these services must be received by Wisconsin Medicaid within one year of when the HealthCheck screen was dated.*
- c. A multidisciplinary day treatment services plan. The treatment plan must be signed by a psychiatrist or psychologist.* Per HFS 40.10(4), Wis. Admin. Code, a psychiatrist or Ph.D. psychologist shall sign the treatment plan, signifying the services identified in the plan are necessary to meet the mental health needs of the child. Revisions in treatment plans also need to be approved by the program psychiatrist or Ph.D. psychologist.
- d. A substance abuse assessment may be included. A substance abuse assessment *must* be included if substance abuse-related programming is part of the recipient's treatment program.

I attest to the accuracy of the information on this PA request.

17. **SIGNATURE** — Day Treatment Program Director

18. Date Signed

* One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of health care providers in psychology.